City of Scottsdale
Employee Medical Insurance Waiver Request

Instructions to employee: (a) Complete the top portion of this form; (b) If applicable, forward the form to the insured's employer for certification; and (c) Return the completed form to the City of Scottsdale Human Resources office.

City of Scottsdale Employee Name	Employee Number

I, hereby request waiver of employee participation in the group medical insurance available to me through the City of Scottsdale. As indicated by the certification below, I am covered by a group medical insurance program offered through another employer. I understand that should I lose coverage due to a family status change, I have thirty (30) days in which to enroll in the City of Scottsdale group medical insurance program.

City of Scottsdale Employee Signature _____ Employee's Department _____ Date _____

☐ **WAIVING COVERAGE, HAS NO OTHER HEALTH INSURANCE**
(Available for Part Time employees only. Full time employees must select the Employee Only EPO coverage option at no cost.)

If you waive health insurance and do not have other health insurance and then have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the date of the marriage, birth, adoption, or placement for adoption. You may also elect health insurance coverage during a future open enrollment period. See back of form for more information.

☐ **WAIVING COVERAGE, HAVE OTHER HEALTH INSURANCE**

Insured's Name	Identification Number
Insured's Employer Name	Insurance Company Name

Insured's Signature Authorizing Release of Information _____ Insured's Phone Number _____

Instructions to Employer: Please complete the Certification of Coverage portion of this form, and return it to the address below as soon as possible.

CERTIFICATION OF COVERAGE

Our City of Scottsdale employee indicated that coverage is provided for them:
☐ As an employee or retiree of your company
☐ As a dependent under your employee listed above Is this COBRA coverage? _____ Yes _____ No

Our records indicate that the above-named City of Scottsdale employee is presently being covered under our group medical program as indicated above.

Signature _____ Phone Number _____

Title _____ Date _____

Return Completed Form to:

Waivers must be returned by:
November 7, 2003

City of Scottsdale, Human Resources
7575 E. Main St.
Scottsdale, AZ 85251
Phone (480) 312-7600 Fax (480) 312-7960

HR Use Only
Verified By: _____
Date: _____

Waiving Coverage Because of Other Health Insurance
If you are declining enrollment for yourself or your dependents (including spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in a City of Scottsdale health insurance plan, provided that you request within 30 days after your other coverage ends or if you request health insurance during a future open enrollment period.

Conditions of Special Enrollment
If the other coverage was COBRA coverage, then the COBRA coverage must be exhausted for the special enrollment to apply. If the other coverage was not COBRA coverage, then the other coverage must terminate because of one of the following:
1. Employer contributions towards the coverage has been terminated, or
2. Loss of eligibility under the other coverage, such as:
    - Termination of employment or eligibility, or reduction in work hours
    - Legal separation
    - Divorce
    - Death

Loss of eligibility does not include: (1) Loss of coverage due to the failure of the individuals to pay premiums on a timely basis, or (2) Termination of coverage for cause, such as fraudulent claims and/or intentional misrepresentation of material fact in connection with the plan.

Documentation required:
Written verification of the loss of coverage is required. Acceptable documentation would be the COBRA letter indicating the loss of the other coverage, the death certificate, or the court documents for the divorce or legal separation.